General Assembly **Substitute Bill No. 6796**

January Session, 2001

AN ACT CONCERNING THE CHOICES HEALTH INSURANCE ASSISTANCE PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-427 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) As used in this section:

(1) The "CHOICES health insurance assistance program" means the federally recognized state health insurance assistance program funded pursuant to P.L. 101-508 and administered by the Department of Social Services, in conjunction with the area agencies on aging and the Center for Medicare Advocacy, that provides free information and assistance related to health insurance issues and concerns of older persons and other Medicare beneficiaries in Connecticut; and

(2) "CHOICES" means Connecticut's programs for health insurance assistance outreach information and referral, counseling and eligibility screening.

[(a)**]** (b) The Department of Social Services shall **[**establish a program to provide assistance to Medicare**]** administer the CHOICES health insurance assistance program, which shall be a comprehensive Medicare advocacy program that provides assistance to Connecticut residents who are Medicare beneficiaries. The program shall: (1) **[**Provide for**]** Maintain a toll-free telephone number to provide advice

and information on Medicare benefits, **[**and**]** the Medicare appeals process **[**from**]** and other health insurance matters applicable to Medicare beneficiaries at least five days per week during normal business hours; (2) provide information, advice and representation, where appropriate, concerning the Medicare appeals process, by a qualified attorney or paralegal at least five days per week during normal business hours; **[**and (2) provide for the preparation and distribution of**]** (3) prepare and distribute written materials to Medicare **[**patients**]** beneficiaries, their families, **[**and**]** senior **[**citizen**]** citizens and organizations regarding Medicare benefits; (4) develop and distribute a Connecticut Medicare consumers guide, after consultation with the Insurance Commissioner and other organizations involved in servicing, representing or advocating for Medicare beneficiaries, which shall be available to any individual, upon request, and shall include: (A) Information permitting beneficiaries to compare their options for delivery of Medicare services; (B) information concerning the Medicare plans available to beneficiaries, including the traditional Medicare fee-for-service plan and the benefits and services available through each plan; (C) information concerning the procedure to appeal a denial of care and the procedure to request an expedited appeal of a denial of care; (D) information concerning private insurance policies and federal and state-funded programs that are available to supplement Medicare coverage for beneficiaries; (E) a worksheet for beneficiaries to use to evaluate the various plans; and (F) any other information the program deems relevant to beneficiaries; and (5) include any functions the department deems necessary to conform to federal grant requirements.

(c) The Insurance Commissioner, in cooperation with, or on behalf of, the Commissioner of Social Services, may require each Medicare organization to: (1) Annually submit to the commissioner any data, reports or information relevant to plan beneficiaries; and (2) at any other times at which changes occur, submit information to the commissioner concerning current benefits, services or costs to beneficiaries. Such information may include information required

under section 38a-478c.

(d) Each Medicare organization that fails to file the annual data, reports or information requested pursuant to subsection (c) of this section shall pay a late fee of one hundred dollars per day for each day from the due date of such data, reports or information to the date of filing. Each Medicare organization that files incomplete annual data, reports or information shall be so informed by the Insurance Commissioner, shall be given a date by which to remedy such incomplete filing and shall pay said late fee commencing from the new due date.

(e) Not later than June 1, 2001, and annually thereafter, the Insurance Commissioner, in conjunction with the Managed Care Ombudsman, shall submit to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to human services and insurance and to the select committee of the General Assembly having cognizance of matters relating to aging, a list of those Medicare organizations that have failed to file any data, reports or information requested pursuant to subsection (c) of this section.

[(b)**]** (f) All hospitals, as defined in section 19a-490, which treat persons covered by Medicare Part A shall: (1) Notify incoming patients covered by Medicare of the availability of the services established pursuant to subsection **[**(a)**]** (b) of this section, (2) post or cause to be posted in a conspicuous place therein the toll-free number established pursuant to subsection **[**(a)**]** (b) of this section, and (3) provide each Medicare patient with the toll-free number and **[**directives on**]** information on how to access **[**to**]** the CHOICES program.

Sec. 2. Section 17b-427a of the general statutes is repealed.

Sec. 3. This act shall take effect from its passage.

HS *JOINT FAVORABLE SUBST.*